MEDI-CAL CHOICE FORM

Use this form to change health plans. For free help filling out this form, call **1-800-430-4263**.

Mail completed form to: **California Department of Health Care Services • Health Care Options • Box 959009, W. Sacramento, CA 95798-9850**.

Please print. Use a blue or black pen. Completely fill in the ovals ⬬ to show your choice.

Head of Household Name (First Name, Last Name) | ○ M ○ F Sex | Telephone Number

Home Address (House Number, Street, Apartment Number, City, and Zip Code)

1st Applicant Name (First Name, Last Name) | ○ M ○ F Sex | Due Date (if pregnant) | Social Security Number

HEALTH PLANS

I want to be in:

- ○ Blue Cross (fill in Doctor/Clinic Code)
- ○ Care 1st (fill in Doctor/Clinic Code)
- ○ HealthNet (fill in Doctor/Clinic Code)
- ○ Kaiser (fill in Doctor/Clinic Code)
- ○ Western Health Advantage (fill in Doctor/Clinic Code)
- ○ Regular Medi-Cal

Doctor/Clinic Code

(To find the code number, look in the Provider Directory for the plan you are choosing. The code number is usually written under the name of your provider. It can also be called a "PCP#" or "Provider Identification Number.")

Enter the code letter for the reason you are changing your health plan.* ☐

(To find the code letter, look at the bottom of this form.)

2nd Applicant Name (First Name, Last Name) | ○ M ○ F Sex | Due Date (if pregnant) | Social Security Number

HEALTH PLANS

I want to be in:

- ○ Blue Cross (fill in Doctor/Clinic Code)
- ○ Care 1st (fill in Doctor/Clinic Code)
- ○ HealthNet (fill in Doctor/Clinic Code)
- ○ Kaiser (fill in Doctor/Clinic Code)
- ○ Western Health Advantage (fill in Doctor/Clinic Code)
- ○ Regular Medi-Cal

Doctor/Clinic Code

(To find the code number, look in the Provider Directory for the plan you are choosing. The code number is usually written under the name of your provider. It can also be called a "PCP#" or "Provider Identification Number.")

Enter the code letter for the reason you are changing your health plan.* ☐

(To find the code letter, look at the bottom of this form.)

3rd Applicant Name (First Name, Last Name) | ○ M ○ F Sex | Due Date (if pregnant) | Social Security Number

HEALTH PLANS

I want to be in:

- ○ Blue Cross (fill in Doctor/Clinic Code)
- ○ Care 1st (fill in Doctor/Clinic Code)
- ○ HealthNet (fill in Doctor/Clinic Code)
- ○ Kaiser (fill in Doctor/Clinic Code)
- ○ Western Health Advantage (fill in Doctor/Clinic Code)
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Doctor/Clinic Code

(To find the code number, look in the Provider Directory for the plan you are choosing. The code number is usually written under the name of your provider. It can also be called a "PCP#" or "Provider Identification Number.")

Enter the code letter for the reason you are changing your health plan.* ☐

(To find the code letter, look at the bottom of this form.)

***Codes for Reasons for Change:**

Code A: I could not choose the doctor I wanted
Code B: The plan did not meet my needs
Code C: My doctor did not meet my needs
Code D: I had to go too far to see my doctor
Code E: I did not choose this plan
Code F: I am moving out of the county
Code G: Other

Statement of Understanding: I understand that by filling out and signing this form, I am choosing how to get my Medi-Cal health care. I understand that the Department of Health Care Services will keep the information on this form. They will only use it to enroll or disenroll me from a Medi-Cal Health Plan. Other government agencies that serve Medi-Cal members can also see this information. I can look at the files that Medi-Cal keeps on me, unless they are being used in an investigation or lawsuit. (To see your Medi-Cal file, contact the Department of Health Care Services at the address at top.)

If You Chose a Medi-Cal Health Plan: I have read the description of the plan I want to join.

If You Join Kaiser: I understand that Kaiser requires binding arbitration. This means that I give up my right to a jury or court trial for medical malpractice and other disagreements about benefits and services. Instead, I would help choose independent professionals who would make a decision about the problem. I can still ask for a Medi-Cal State Hearing.

Highly Confidential

Head of Household's Signature | Date

2nd Applicant's Signature (if under 18, parent or guardian) | Date

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1st Applicant's Signature (if under 18, parent or guardian) | Date

3rd Applicant's Signature (if under 18, parent or guardian) | Date